# Community Hospital Task Force

March 11, 2008

## Outline

- Updated workplan
- Review Task Force recommendations
  - Payment methodology
  - Pay-for-quality program
- Review Medicaid's next steps
- Policy options for RIte Care and commercial payment to hospitals

# CHTF – Updated Workplan

| Element of payment method | On Task Force agenda? | Discussion date |
|---|---|---|
| 1. Principles of payment | Yes | 11/27/07 |
| 2. Base rate | No | N/A |
| 3. Recommendation of DRG grouper | Yes | 12/12/07, 12/19/07 |
| Initial discussion of options for other payers | Yes | 1/7/08 |
| 4. Policy adjuster weights for certain groups of DRGs | Yes | 1/22/08, 2/12/08 |
| 5. Non-DRG-specific policy-based add-ons (e.g., for quality) | Yes | 2/27/08 |
| 6. Detailed design document | No | |
| Design / implementation plan and options for other payers | Yes | 3/11/08 |

# TF recommendations to Medicaid: adjustors to APR-DRG formula (from last meeting)

Payment for Particular DRG =
[Base rate X (DRG weight X policy adjuster weight)]
+ quality + other policy add-ons

1. Policy adjusters should be calibrated to be sufficient to maintain Medicaid FFS access for mental health and neo-natal care.
2. Minimize financial impact of any change in payment methodology to non-teaching community hospitals* as a group

*Kent, Landmark, Newport, St. Joseph's South County, Westerly

## TF recommendations to Medicaid (cont.)

3. Medicaid inpatient payments appear to cover hospital costs in total but analytical methodology needs review.
4. Include value-based purchasing as a principle (pay-for-quality – see next page)

## TF's recommended principles on Pay-for-Quality

1. Minimize administrative burden to hospitals
   - Work with hospital quality staff to assure this
2. Design program to enhance, not inhibit, collaboration between hospitals on quality improvement
3. Design quality incentives to enhance revenue of those that attain and improve on quality measures

# Medicaid FFS Pay for Quality: recommended policies

1. Use publicly reported measures (from DOH/Medicare)
2. Measures reflect care delivered to all patients (not just Medicaid patients)
3. Reward both improvement and attainment on selected quality measures
4. Funds available for quality payments are between 1-3% of total anticipated Medicaid FFS payments to all hospitals (globally budget neutral)
5. Use Health Care Quality Steering Committee to design P4Q program

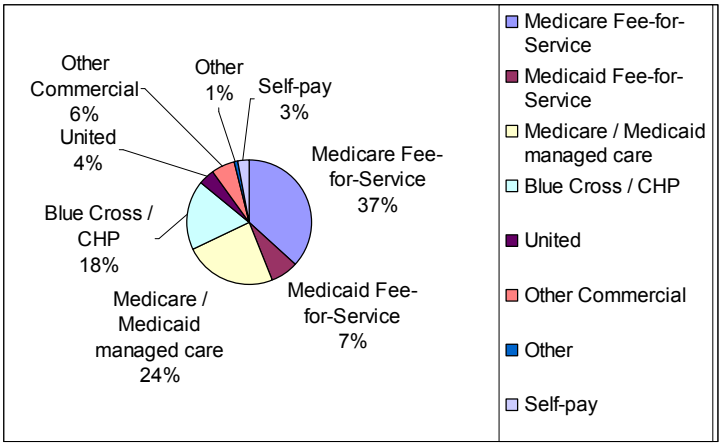
# Medicaid – Next steps

- Finalize APR-DRG methodology using internal working group.
  - Use recommended policy direction from Task Force
  - Next meeting with CFOs in April to ensure that decisions are made using the most accurate data
  - Works with Health Care Quality Steering Committee to design P4Q program between 7/1/08 – 12/31/08
- Periodic review of inpatient APR-DRG base rate to be conducted by DHS
- Outpatient payment methodology is next

Commercial Payments
(second part of the charge)

Why did CHTF get the charge to examine payment methods and amounts?

Concerned about Financial Health of Hospitals?
Follow the patients.




Average % of inpatients covered by each payer in community hospitals (2006)

## There is variation in the amount hospitals are paid for similar inpatient services.

| | # Community Hospitals | | | |
|---|---|---|---|---|
| % difference from Referent Hospital[1] | BCBSRI | United | Medicaid | Medicare |
| 100 to 120% | 6 | 5 | 1 | 7 |
| 121 to 140% | 1 | 0 | 3 | 1 |
| 141 to 160% | 1 | 3 | 1 | |
| 161% | | | 3 | |

[1] Comparing each hospitals average per diem reimbursement to the lowest reimbursed hospital by each insurer.

Source: DOH analysis. Fuller picture would require analysis of outpatient payments

## Comparison of populations

| | **Medicaid FFS** | **RIte Care** | **Commercial** |
|---|---|---|---|
| Number of Lives (approx.) | 64,000 | 120,000 | 600,000 |
| Size of Hospital Inpatient Payments (estimated) | $145 million | $85 million | $400 million |
| Size of Outpatient Payments (estimated) | $45 million | $65 million | $500 million |
| State's Role | Payer | Purchaser | Regulator of Conduct and Premium |
| | | | . |

# Discussion last time (Jan. 7th): Issues Covered.

1. Applicability of Medicaid FFS to RIte Care and Commercial
2. If a similar methodology was chosen, what are some of issues:
   1. Merits of similarity of inpatient methodology
   2. Choice of DRG grouper
   3. Base rate determination
   4. Policy adjusters / Quality Payments
   5. Price transparency

# Applicability of Medicaid FFS inpatient payment to RIte Care/ Commercial

- RIte Care: "It depends"
  - Historically have not imposed conditions on plans' negotiations with providers.
  - Any adoption of Medicaid payment methodology would have to have own policy adjustors (different population from Medicaid) and be budget neutral for RIte care
- (Valuable lessons for commercial applications)

Source: Comments from TF meetings

## Similarity of methodology

- Principles:
  - The reason for adopting a payment methodology similar to Medicaid for commercial market should be that it has a measurable and known benefit to community hospitals.
  - Would this methodology enhance hospitals' efficiency?

Source: Comments from TF meetings

## Choice of DRG grouper

- Choice of a grouper should be made depending on whether the population is more similar to Medicare or Medicaid.
- Hospitals don't appear to all prefer DRG-based system.

Source: Comments from TF meetings

## Base rate: How calculated?

- Similarity in base rate would allow hospitals to compete on quality and efficiency
  - Base rate must be evidence based
  - Same base rate gets at issue of “fairness”
- Valid differences in cost structure across hospitals might make different base rates preferable

Source: Comments from TF meetings

## Policy Adjusters / Quality Payments

- Who would make decision on which policy adjusters are appropriate?
- Do hospitals need financial incentives to increase quality?

Source: Comments from TF meetings

# Price Transparency

- Payer concern: Complete transparency could have an impact on affordability (drive prices up)
- Consumers: Transparency is necessary for accountability and fairness.

Source: Comments from TF meetings